Humana Employee Enrollment Application - 51-99 Employees ILLINOIS

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

HMO plans offered by Humana Health Plan, Inc. PPO, and Traditional Preferred plans and Life and Short-term income protection plans insured or administered by Humana Insurance Company. Dental PPO and Traditional Preferred plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company. Dental prepaid plans and AdvantagePlus dental plans offered and administered by CompBenefits Dental, Inc. CompBenefits Vision plan insured and administered by CompBenefits Insurance Company.

Please print clearly and fill in each applicable circle.

Medical Group number | Benefit number | Division

Company name | Proposed Effective Date _ _ / _ _ / _ _ _ _

Company city | State

Employee Information

IL-80124-GN 12/2007

Last name | First name | MI | Date of birth _ _ / _ _ / _ _ _ _

Social Security number | Phone number

Gender: ❍ Female ❍ Male | Email address

Street address | Apt / Suite / PO Box number

City | State | Zip code | County

Language of choice: ❍ English ❍ Spanish

Employment status: Number of hours worked per week | Date of full-time hire _ _ / _ _ / _ _ _ _ | ❍ Full-time employee ❍ Retiree

Are you disabled or unable to perform normal activities? ❍ No ❍ Yes If yes, indicate reason:

Dependent Information

IL-80124-DP 12/2007

Please enter information for each dependent, including spouse, applying for coverage. For additional dependents, copy and attach an additional Dependent Information form.

1. Last name | First name | MI | Date of birth _ _ / _ _ / _ _ _ _

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

HMO only:
Primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

Prepaid Only: Dentist name | Current Patient: ❍ No ❍ Yes

2. Last name | First name | MI | Date of birth _ _ / _ _ / _ _ _ _

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

HMO only:
Primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

Prepaid Only: Dentist name | Current Patient: ❍ No ❍ Yes

3. Last name | First name | MI | Date of birth _ _ / _ _ / _ _ _ _

Social Security number | Gender: ❍ Female ❍ Male | Relationship: ❍ Spouse ❍ Child ❍ Other:

Dependent status (if applicable): ❍ Full-time student ❍ Disabled | If disabled, indicate reason:

HMO only:
Primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

Prepaid Only: Dentist name | Current Patient: ❍ No ❍ Yes

Group Number | Social Security Number

Medical

IL-80124-MD 12/2007

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ Other

Plan name | Network name

HMO only:
Employee primary care physician | Physician ID | Current Patient: ❍ No ❍ Yes

Concurrent medical coverage:

• Will you or any of your covered dependents have any other individual or other group medical coverage, including Medicare, in effect at the same time as this Humana coverage? ❍ No ❍ Yes
If yes, please complete below.

Individual or other group medical coverage:

Medical carrier name

Policy number | Effective date _ _ / _ _ / _ _ _ _

Carrier phone number | Term date _ _ / _ _ / _ _ _ _

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family

Medicare coverage:

Employee Coverage: ❍ No ❍ Yes | Effective date _ _ / _ _ / _ _ _ _

Medicare ID | Term date _ _ / _ _ / _ _ _ _

Spouse Coverage: ❍ No ❍ Yes | Effective date _ _ / _ _ / _ _ _ _

Medicare ID | Term date _ _ / _ _ / _ _ _ _

Prior medical coverage: (This section must be completed in order for Humana to process any medical claims.)

• Within the past 12 months, have you or any of your covered dependents had any other individual or other group medical coverage, including Medicare? ❍ No ❍ Yes If yes, please complete below.

Individual or other group medical coverage:

Prior medical carrier name

Policy number | Effective date _ _ / _ _ / _ _ _ _

Prior carrier phone number | Term date _ _ / _ _ / _ _ _ _

Prior coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family

Medicare coverage:

Prior Employee Coverage: ❍ No ❍ Yes | Effective date _ _ / _ _ / _ _ _ _

Medicare ID | Term date _ _ / _ _ / _ _ _ _

Prior Spouse Coverage: ❍ No ❍ Yes | Effective date _ _ / _ _ / _ _ _ _

Medicare ID | Term date _ _ / _ _ / _ _ _ _

Dental

IL-80124-HD 12/2007

Group number | Benefit number | Class/Division

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ Other

Plan name

Prepaid Only: Dentist name | Current Patient: ❍ No ❍ Yes

Within the past 12 months, have you had any individual or other group dental coverage? ❍ No ❍ Yes | Orthodontia coverage? ❍ No ❍ Yes

Effective date _ _ / _ _ / _ _ _ _ | Term date _ _ / _ _ / _ _ _ _

Prior coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family

Basic Life

IL-80124-BL 12/2007

Group number | Benefit number | Class/Division

Primary beneficiary name | Secondary beneficiary name

Class (employer will provide you with this information if needed) | Annual salary (if applicable) $

Basic dependent life: ❍ No ❍ Yes If no, complete waiver section.

Voluntary Life

IL-80124-VL 12/2007

Group number | Benefit number | Class/Division

Do you elect voluntary employee life coverage? ❍ No ❍ Yes | Amount (minimum of $15,000) $ | Annual salary $

Primary beneficiary name | Secondary beneficiary name

Voluntary dependent life: (available only if employee elects voluntary life coverage) Do you elect voluntary child(ren) life coverage? ❍ No ❍ Yes

Do you elect voluntary spouse life coverage? ❍ No ❍ Yes | Amount (minimum of $5,000) $

Vision

IL-80124-VS 12/2007

Group number | Benefit number | Class/Division

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ Other

Plan name

Group Number	Social Security Number

Short-term Income Protection

IL-80124-SP 12/2007

Group number | Benefit number | Class/Division

Do you elect short-term income protection coverage? ❍ No ❍ Yes Annual salary $

Class (employer will provide if needed)

Medical Health History

IL-80124-MH 12/2007

This information should not be submitted more than 60 days prior to the effective date.

1. Within the past 24 months have you or any dependent had or been treated for an illness or injury or had surgery or hospitalization recommended? ❍ No ❍ Yes
2. Within the past 24 months have you or any dependent been prescribed medication? ❍ No ❍ Yes
3. Are you or any dependent currently pregnant? ❍ No ❍ Yes; Incurred medical expenses in excess of $7,500 in the past 12 months? ❍ No ❍ Yes

If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets if necessary.

Question number | Person treated last name | First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed _ _ / _ _ / _ _ _ _ Date last seen by a doctor for this condition _ _ / _ _ / _ _ _ _

Question number | Person treated last name | First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed _ _ / _ _ / _ _ _ _ Date last seen by a doctor for this condition _ _ / _ _ / _ _ _ _

Question number | Person treated last name | First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed _ _ / _ _ / _ _ _ _ Date last seen by a doctor for this condition _ _ / _ _ / _ _ _ _

Question number | Person treated last name | First name

Condition

List symptoms encountered

List treatments received

List medical tests administered

Medication(s) if any

Date condition was first diagnosed _ _ / _ _ / _ _ _ _ Date last seen by a doctor for this condition _ _ / _ _ / _ _ _ _

Group Number	Social Security Number

Health Savings Account

IL-80124-HA 12/2007

Group number | Benefit number | Class/Division

Do you elect the health savings account? ❍ No ❍ Yes

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Waiver (Refusal of coverage)

IL-80124-WV 12/2007

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action. I hereby waive coverage for (check all that apply):

Medical for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)	Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)
Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)	Short-term income protection for: ❍ Myself
Basic life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)	Health savings account for: ❍ Myself

I decline to apply for group coverage because of (check all that apply): ❍ Spousal coverage ❍ Medicare supplement ❍ Individual coverage
❍ Coverage under another carrier's plan provided by my employer ❍ Other:

I understand and agree:

- In the event that I should decide to apply for such coverage hereafter, that such subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions as described in the Summary Plan Description which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.

Group Number	Social Security Number

Agreement

IL-80124-AA 12/2007

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Authorization

My dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, Humana can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- If selecting the Health Savings Account (HSA), you authorize Humana or our banking partners to provide your account number to your employer for the purposes of depositing any contributions.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representative upon written request.
- A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for two years from the date shown below.
- I have the right to revoke this authorization at any time:
  - To revoke this authorization, I must do so in writing and send my written revocation to Humana's Privacy Office.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation will become effective after it is received by Humana's Privacy Office.

Signature - please sign below if enrolling or waiving group coverage

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____